Disability Insurance Claim

Jefferson-Pilot
Life Insurance Company
417 — Individual Health Division
PO Box 20727
Greensboro, NC 27420

Jefferson Pilot

Claimant's Name	Age	Policy No.	Telephone No.	Social Security No.
CHRISTOPHER L. KEARNEY				

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 6-9, 19 93 Claimant's Signature Christopher L. Kearney

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Attending Physician's Statement

1. Diagnosis and Concurrent Conditions (if code other than ICDA* used, give name and if pregnancy show E.D.C.)

ment

2. Date symptoms first appeared or accident happened. 2-4-93

3. Date patient consulted you for this condition. 4-30-93

4. Patient still under your care for this condition? ☒ Yes ☐ No

5. Did condition(s) arise out of patient's employment? ☒ Yes ☐ No

6. Dates of Services 4/30/93 – 6/11/93 (15 Visits)

7. Patient ever had same or similar condition? ☒ Yes ☐ No
(If "Yes", when and describe:)
11/27/89

8. Patient was continuously totally disabled (unable to work)
From 2/5/93 Thru 2/8/93

9. Patient was partially disabled.
From 2/8/93 Thru present DAY

10. If still disabled, date patient should be able to return to work.
tentatively Aug. 1, 1993

11. Does patient have other health coverage? ☐ Yes ☐ No
(If "Yes", please identify:)
UNKNOWN

12. Remarks the patient did not have any pain or other conditions since he was seen in 1989.

Date	Physician's Name (Print)	Signature	Degree	Telephone
6/11/93	Ambrose S. Perdak Jr. DC		Doctor of Chiropractic	513 733 0070

Street Address	City or Town	State or Province	Zip Code
11071 Main St	Cincinnati	OH	45241

Employer's Statement

1. Employee's Name CHRISTOPHER L. KEARNEY
Date Last at Work Part-time ____, 19__
Date Last at Work Full-time ____, 19__

2. Has employee returned to all of his or her work? (If "Yes" give date ____, 19__) ☐ Yes ☐ No

3. Has he or she returned to part of his or her work? (If "yes", give date and list important duties employee is unable to perform.) Feb 9, 1993 Unable to spend as much time on job ☒ Yes ☐ No

4. Is he or she filing for Workmen's Compensation benefits? ☒ Yes ☐ No

5. Has employment with you been terminated? (If "Yes", give date and reason.) ____, 19__ ☐ Yes ☒ No

6. Does your firm pay any portion of the cost of this coverage? (If "Yes", what percent of premium 100 %) ☒ Yes ☐ No

7. Is this coverage part of a **Salary Reduction** Cafeteria Plan? ☐ Yes ☒ No

EXHIBIT K

KEARNEY ASSOCIATES, INC.
Name of Firm

Christopher L. Kearney
Signature and title of person completing this form

Date 6-9, 19 93 Address ____

____ Telephone No.

WJ-291 Rev 7-90

*ICDA - International Classification of Diseases